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A Review of Medical Child Support: Background, Policy, and Issues

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Summary

Medical child support is the legal provision of payment of medical, dental, prescription, and other health care expenses of dependent children. It can include provisions to cover health insurance costs as well as cash payments for unreimbursed medical expenses. According to 2001 Child Support Enforcement (CSE) data, 93% of medical child support is provided in the form of health insurance coverage. The requirement for medical child support is apart of all child support orders (administered by CSE agencies), and it only pertains to the parent's dependent children. Activities undertaken by CSE agencies to establish and enforce medical child support are eligible for federal reimbursement at the CSE matching rate of 66%.

The medical child support process requires that a state CSE agency *notify* the employer of a noncustodial parent who owes child support, that the parent is obligated to provide health care coverage for his or her dependent children. CSE agencies notify employers of a medical child support order via a standardized federal form called the National Medical Support Notice. The plan administrator must then determine whether family health care coverage is available for which the dependent children may be eligible. If eligible, the plan administrator is required to enroll the dependent child in an appropriate plan, and notify the noncustodial parent's employer of the premium amount to be withheld from the employee's paycheck.

Although establishment of a medical support order is a prerequisite to enforcing the order, inclusion of a health insurance order does not necessarily mean that health insurance coverage is actually provided. According to CSE program data, in 2001, only 49% of child support orders included health insurance coverage, and the health insurance order was complied with in only 18% of the cases. Most policymakers agree that health care coverage for dependent children must be available, accessible, affordable, and stable. Since 1977 and sporadically through 1998, Congress has passed legislation to help states effectively establish and enforce medical child support. The National Medical Support Notice, mandated by 1998 law and promulgated in March 2001, was viewed as a means to significantly improve enforcement of medical child support — to date only about half the states are using the Notice. The 1998 law also called for an advisory body to design a medical child support incentive which would become part of the CSE performance-based incentive payment system — a recommendation was made to Congress in 2001 to indefinitely delay development of a medical child support incentive mainly because it was argued that the appropriate data was not yet available upon which to base such an incentive.

Improving the establishment and enforcement of medical child support has been hampered to some extent by factors such as high health care costs, a decline in employer-provided health insurance coverage, an increase in the share of health insurance costs borne by employees, and the large number of uninsured children. This report provides a legislative history of medical support provisions in the CSE program, describes current policy with respect to medical child support, examines available data, and discusses some of the issues related to medical child support. This report will not be updated.

Contents

List of Figures

List of Tables

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Background

Most Americans view health care for their children and for themselves as one of their top concerns. The adverse consequences of going without health insurance may include unmet health and dental needs, lower receipt of preventive services, avoidable hospitalizations, increased likelihood of receiving expensive emergency room care, and reduced likelihood that the doctor is familiar with the patient's medical history. From a public health perspective, early and frequent monitoring of children's health is a key component to ensuring the appropriate growth and healthy development of children. From a family perspective, health insurance coverage greatly reduces parental financial and emotional stress. Medical child support benefits families by increasing the incidence of noncustodial parents who obtain private health insurance coverage for their dependent children. With medical child support, Congress found a way to make noncustodial parents responsible for their children and lessen taxpayer burden by shifting costs from the taxpayers back to the noncustodial parents.

Since 1977, Congress has tried to offset some of the costs associated with the Medicaid program by allowing states to require Medicaid recipients to assign their child support rights to the state and allowing the state to pursue reimbursement of the cost of Medicaid benefits provided to the child from the child's noncustodial parent (in 1984 mandatory assignment became law). Since 1984, Congress has tried to increase provision of private health care coverage for children whose noncustodial parent has access to employer-related or group health insurance that is provided at a reasonable cost. This is seen as a way to make noncustodial parents responsible for their children and lessen taxpayer burden by shifting costs from the taxpayers back to the noncustodial parents. For a detailed legislative history, see **Appendix A**.

In 1984, federal law required that state Child Support Enforcement (CSE) agencies petition for the inclusion of medical support as part of any child support order whenever health care coverage is available to the noncustodial parent at reasonable cost. A 1993 amendment to the Employee Retirement Income Security Act (ERISA) required employer-sponsored group health plans to extend health care coverage to the children of a parent/employee who is divorced, separated, or never married when ordered to do so by the state CSE agency via a Qualified Medical Child Support Order (QMCSO). The 1996 welfare reform law further strengthened medical support by stipulating that all orders enforced by the state CSE agency must

include a provision for health care coverage.[1] The 1996 law also directed the CSE agency to notify the noncustodial parent's employer of the employee's medical child support obligation. To help obtain health care coverage for children, a 1998 law authorized the creation of the National Medical Support Notice (NMSN), a standardized form, that is the exclusive document which must be used by all state CSE agencies. An appropriately completed NMSN is considered to be a "Qualified Medical Child Support Order," and as such must be honored by the noncustodial parent's employer's group health plan.

The reader should recognize that efforts to improve the establishment and enforcement of medical child support need to be viewed in the current context of high health care costs, a decline in employer-provided health insurance coverage (which is the foundation of the current medical child support system), an increase in the share of health insurance costs borne by employees, and a large number of children who are uninsured. Moreover, cash support and medical support are not always compatible. For example, if premiums, co-payments, and deductibles of noncustodial parents rise, fairness might suggest that the cash child support payment of noncustodial parents be reduced to reflect payment of additional medical costs. The result, however, would be that custodial parents would have less income to provide for the basic food, clothing, and shelter needs of their dependent children; conversely, if medical support is not available, the family will undoubtedly face dire economic circumstances if a child becomes seriously ill.

The public and policymakers generally agree that establishment and enforcement of medical support, where it is available on reasonable terms, promotes family responsibility, improves children's access to health care, and usually saves federal and state dollars. This report provides a legislative history of medical support provisions in the CSE program, describes current policy with respect to medical child support, examines data on medical child support, and discusses some of the issues related to medical child support.

Current Policy

Federal law mandates that states have procedures under which all child support orders are required to include a provision for the health care coverage of the child (section 466(a)(19) of the Social Security Act). Medical support is the legal provision of payment of medical, dental, prescription, and other health care expenses for dependent children by the noncustodial parent. It can include provisions to cover health insurance costs as well as cash payments for unreimbursed medical expenses. The requirement for medical child support is a part of the child support order, and it only pertains to the parent's dependent children. The reader should note that states can establish child support orders (and thereby medical child support orders) either

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[1] CSE agency staff carry out this duty by determining the employment status of the noncustodial parent and whether health insurance coverage is available for his or her dependents. If such coverage is available, the CSE agency notifies the employer of the employee's medical child support obligation and the employer's responsibility to thereby enroll the dependents of the employee in the health care plan.

by a judicial or administrative process (i.e., through the state courts or through the state CSE agencies). Activities undertaken by the state CSE agencies to establish and enforce medical support are eligible for federal reimbursement at the general CSE matching rate of 66%.[2]

Medical support can take several forms. The noncustodial parent may be ordered to: (1) provide health insurance if available through his or her employer, (2) pay for private health insurance (health care coverage) premiums or reimburse the custodial parent for all or a portion of the costs of health insurance obtained by the custodial parent for the child, or (3) pay additional amounts to cover some or all of ongoing medical bills as reimbursement for uninsured medical costs.[3]

National Census Data
1999 — 56% of child support orders included health insurance coverage; parents complied with 49% of these health insurance orders

CSE Program Data
2001 — 49% of child support orders included health insurance coverage; parents complied with 49% of these health insurance orders

Congress has realized for many years that medical support enforcement activities need to be strengthened. Congress recognized early in the implementation of the CSE program that many noncustodial parents had private health insurance coverage available through employers, unions or other groups and that such coverage could be extended when available at reasonable cost to provide for dependents' medical expenses. The medical child support provisions benefit families by increasing the incidence of noncustodial parents who obtain health insurance coverage for their dependent children. Moreover, the medical child support provisions result in cost savings to states and the federal governments by reducing Medicaid expenditures when such health care insurance is available to families who are eligible for Medicaid services.[4]

According to federal regulations (45 CFR 303.31), for both families who have assigned their medical support rights to the state and families who have applied for CSE services, the CSE agency must:

> (1) Petition the court or administrative authority to include in the child support order health insurance that is available to the noncustodial parent at reasonable cost in new or modified child support orders, unless the child has satisfactory health insurance other than Medicaid;

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[2] For background information on the CSE program, see: Congressional Research Service (CRS) Report 97-408, Child Support Enforcement: New Reforms and Potential Issues, by (name# redacted).

[3] U.S. Department of Health and Human Services, Administration for Children and Families, Office of Child Support Enforcement, *Essentials for Attorneys in Child Support Enforcement, 3rd Edition*, 2002 at [http://www.acf.hhs.gov/programs/cse/pubs/2002/reports/essentials/index.html].

[4] U.S. Department of Health and Human Services, Administration for Children and Families, Office of Child Support Enforcement, OCSE-AT-88-15, Action Transmittal, *Medical Support Enforcement*, Sept. 26, 1988.

(2) Petition the court or administrative authority to include medical support whether or not — (a) health insurance at reasonable cost is actually available to the noncustodial parent at the time the order is entered; or (b) modification of current coverage to include the child(ren) in question is immediately possible;
(3) Establish written criteria to identify cases not included under the previous two provisions where there is a high potential for obtaining medical support based on — (a) evidence that health insurance may be available to the noncustodial parent at a reasonable cost, and (b) facts, as defined by state law, regulation, procedure, or other directive, which are sufficient to warrant modification of the existing support order to include health insurance coverage for a dependent child(ren);
(4) Petition the court or administrative authority to modify child support orders for cases that are likely to have access to health insurance to include medical support in the form of health insurance coverage;
(5) Provide the custodial parent with information pertaining to the health insurance policy which has been secured for the dependent child(ren);
(6) Inform the Medicaid agency when a new or modified court or administrative order for child support includes medical support and provide specific information to the Medicaid agency when the information is available;
(7) If health insurance is available to the noncustodial parent at reasonable cost and has not been obtained at the time the order is entered, take steps to enforce the health insurance coverage required by the support order and provide the Medicaid agency with the necessary information;
(8) Periodically communicate with the Medicaid agency to determine if there have been lapses in health insurance coverage for Medicaid applicants and recipients; and
(9) Request employers and other groups offering health insurance coverage that is being enforced by the CSE agency to notify the CSE agency of lapses in coverage.

In addition, a medical child support order must contain the following information in order to be "*qualified*": (1) the name and last known mailing address of the participant and each child covered by the order, except that the order may substitute the name and mailing address of a state or local official for the mailing address of any child covered by the order; (2) a reasonable description of the type of health coverage to be provided (or the manner in which such coverage is to be determined); and (3) the period to which the order applies.

To help obtain health care coverage for children, a 1998 law authorized the creation of the NMSN. The NMSN is a standardized federal form that all state CSE agencies are supposed to use when issuing a medical support order to employers. An appropriately completed NMSN is considered to be a "Qualified Medical Child Support Order," and as such must be honored by the noncustodial parent's employer's group health plan.[5]

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[5] Generally, a state court or agency may require an ERISA-covered health plan to provide health benefits coverage to children by issuing a Qualified Medical Child Support Order; the medical support order is "*qualified*" if it includes the information mentioned above. The (continued...)

Cash child support collections by CSE agencies are distributed in several ways, including in the form of medical support. They may be sent to the family, divided between the state and federal governments, used as incentive payments to states, or used for medical support (and sent to the Medicaid agency or the family). For FY2001, total child support collections were distributed as follows: 87.7% went to families; 5.3% went to the states; 4.7% went to the federal government; 1.8% were paid out as incentive payments to states; and 0.5% was paid as medical support. To the extent that medical support has been assigned to the state, medical support collections are forwarded to the Medicaid agency for distribution. Otherwise, the amount collected as medical support is forwarded to the family.[6] (It should be noted that the provision of medical support in the form of health insurance coverage is not quantified in the above data.)

In general, health insurance is preferred over other types of medical support because it usually is relatively inexpensive for the employee/noncustodial parent (due to the employer contribution), it is easier for the CSE agency to monitor, and it can cover children who otherwise would be dependent on Medicaid benefits (at taxpayer expense).[7] In FY2001, medical support orders were issued in the form of health insurance in 93% of the cases that included a medical support order (see **Table 2**). The conference report on the Child Support Enforcement Amendments of 1984 (which became P.L. 98-378) stated:

> "... the conferees believe that the best long run solution to achieving medical insurance coverage for all families is the use of private medical insurance which is or can be made available through a parent's employer."[8]

The medical child support process requires that a state CSE agency issue a notice to the employer of a noncustodial parent, who is subject to a child support order issued by a court or administrative agency, informing the employer of the parent's obligation to provide health care coverage for the child(ren). The employer must then determine whether family health care coverage is available for which the dependent child(ren) may be eligible, and if so, the employer must notify the plan

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[5] (...continued)
National Medical Support Notice is a federally-required form that serves the same purpose as the QMCSO. The standardized form was designed in consultation with a federal workgroup that included representatives of major employers, payroll associations, insurance administrators and government representatives. Their intent was to provide employers with a standardized set of forms, processes and timeframes — something employers had requested.

[6] In FY2001, medical support payments to families amounted to $94.3 million, up from $32.3 million in FY1994 (and $7.5 million in FY1993, the first year in which data were collected).

[7] U.S. Department of Health and Human Services, Administration for Children and Families, Office of Child Support Enforcement, *Essentials for Attorneys in Child Support Enforcement, 3rd Edition*, 1992, p. 109.

[8] U.S. Congress, Conference Committees, *Child Support Enforcement Amendments of 1984*, conference report to accompany H.R. 4325, 98th Cong., 2nd sess., H.Rept. 98-925 (Washington, GPO, 1984), p. 52-53.

administrator of each plan covered by the National Medical Support Notice. If the dependent child(ren) is eligible for coverage under a plan, the plan administrator is required to enroll the dependent child(ren) in an appropriate plan. The plan administrator also must notify the noncustodial parent's employer of the premium amount to be withheld from the employee's paycheck.[9]

Medical Child Support Data

This section examines data from three different sources: national data from the U.S. Census Bureau, state CSE program data from the federal Office of Child Support Enforcement (OCSE), and longitudinal data from the Survey of Income and Program Participation. All of the data indicate that much more needs to be done to improve the establishment and enforcement of medical support, in accordance with current law. In reviewing the data, it is important to note that (1) in some cases children did not receive a child support award of any kind, cash or medical care; (2) even if there was a cash award, in many cases, health insurance coverage was not included in the award; and (3) even when health insurance coverage was included, in many cases, it was not actually provided by the noncustodial parent.

Census Data

The U.S. Census Bureau periodically collects national survey information on child support. The Census Bureau interviews a random sample of single-parent families to gather data that can be used to assess the performance of noncustodial parents in paying child support and providing health insurance coverage. The Census data are based on all single-parent families in the United States with children under age 21 who are living apart from their other parent. The Census data are more comprehensive than CSE program data but do not disaggregate the data on a state-by-state basis.

Figure 1 displays data obtained from April supplements to the Census Bureau's Current Population Survey. These supplements provide information on the receipt of child support payments by parents living with their own children whose other parent is not living with the family. **Figure 1** only displays information from cases in which the mother is the custodial parent.[10] **Figure 1** indicates that during the period from 1989-1999, the percentage of child support awards that included health insurance increased from 40.1% to 55.6%. Thus, in 1999 about 56% of mothers awarded child support payments had health insurance included in their award. This coincides with congressional efforts to make health care coverage part of the child support obligation. However, the examination of enforcement, i.e., whether health insurance was actually provided, shows a different picture. During the 1989-1999 period, the percentage of child support awards that included health insurance in which health insurance coverage was actually provided by the father dropped almost

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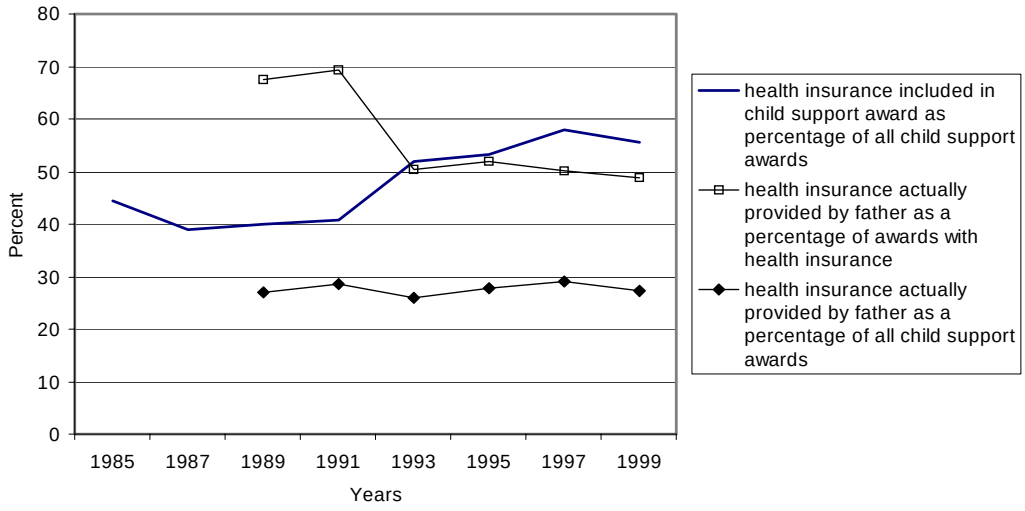
[9] U.S. Department of Labor, Pension and Welfare Benefits Administration, *Federal Register,* v. 65, no. 249, National Medical Support Notice, Dec. 27, 2000, p. 82137.

[10] The 1991 Survey was the first survey to include information on custodial fathers.

28%, from 67.6% in 1989 to 48.9% in 1999. Thus, in 1999, only 49% of custodial mothers expecting to receive health benefits for their children actually did so.

Figure 1. Health Insurance and Child Support Awards



Source: Prepared by the Congressional Research Service based on data from Census Bureau reports.

The third trend line in **Figure 1** looks at cases in which health insurance was actually provided by the father as a percentage of all cases in which child support was awarded (as opposed to just those that included health insurance). It shows a relatively flat line. In other words, during the period 1989-1999, the percentage of cases in which health insurance was required to be provided by the father relative to all cases in which child support was awarded remained relatively unchanged. The percentage was 27.1% in 1989, it jumped to 28.5% in 1991, dropped back to 26.1% in 1993, rose to 27.7% in 1995 and to 29.1% in 1997, and dropped back to 27.2% in 1999. Thus, even though there were some gains in the requirement for provision of health insurance, the actual provision of health insurance to children living with their custodial mothers did not improve much over the 1989-1999 period.

Table 1 provides detailed information for 1999, the most recent year for which national data are available, on the inclusion of the father's health insurance in orders received by families headed by mothers. Although the 1999 survey, like the 1997, 1995, 1993, and 1991 surveys, included custodial fathers, the table and following discussion are focused solely on custodial mothers. While indicating that about 56% of all mothers have health insurance included in their child support award, the table also shows that the probability of health insurance coverage is greatly reduced for never-married women (39%), black (42%) and Hispanic women (42%), and women with less schooling (i.e., high school dropouts, 36%).

Table 1. Child Support Award Status and Inclusion of Health Insurance in Child Support Award, by Selected Characteristics of Custodial Mothers, 1999

Characteristic of custodial mothers	Total (thousands)	Supposed to receive child support payments in 1999		
		Total (thousands)	Health insurance included in child support award	
			Number (thousands)	Percent of total awarded
Current marital status:[a]				
Married	2,588	1,568	1,129	62.8%
Divorced	3,760	2,448	1,753	63.2
Separated	1,329	602	361	49.4
Never married	3,698	1,464	692	38.7
Race/Hispanic origin:[b]				
White	7,858	4,621	3,189	59.9
Black	3,225	1,289	663	42.4
Hispanic	1,728	717	360	42.2
Age:				
15-17 years	83	7	6	21.4
18-29 years	3,344	1,499	822	46.3
30-39 years	4,433	2,554	1,604	55.3
40 years or older	3,368	2,073	1,547	63.2
Years of school completed:				
Less than high school graduate	2,239	888	406	35.8
High school graduate or GED	4,344	2,229	1,463	55.4
Some college, no degree	2,536	1,524	1,051	61.6
Associate degree	1,013	616	411	58.8
Bachelors degree or more	1,367	877	648	66.7

Characteristic of custodial mothers	Total (thousands)	Supposed to receive child support payments in 1999		
		Total (thousands)	Health insurance included in child support award	
			Number (thousands)	Percent of total awarded
Number of own children present from an absent father:				
One child	6,527	3,065	1,978	53.7
Two children	3,367	2,118	1,425	60.7
Three children	1,099	667	425	54.7
Four children or more	507	282	150	44.0
Total	11,499	6,133	3,978	55.6

Source: U.S. Census Bureau. 2002.

Note: Custodial mothers are defined as women 15 years and older with children under 21 years of age present from absent fathers as of Spring 2000.

a. Excludes a small number of currently widowed women whose previous marriage ended in divorce.
b. Persons of Hispanic origin may be of any race.

CSE Program Data

Percentage of Child Support Awards Enforced or Modified that Include a Health Insurance Order

FY1991	35.3%	FY1997	38.9%
FY1992	30.0%	FY1998	34.8%
FY1993	29.7%	FY1999	42.7%
FY1994	32.3%	FY2000	47.0%
FY1995	32.7%	FY2001	49.3%
FY1996	34.2%		

The medical support provisions appear to be having an impact on the number of children in single-parent families with medical coverage in their child support orders. According to CSE program data, which reflect welfare families who are automatically eligible for CSE services and nonwelfare families who have applied for CSE services, 49% of child support orders in FY2001 included health insurance coverage, up from 35% in FY1991. Although the CSE system has been making progress in including health insurance coverage in child support orders, these figures indicate that many children still lack health insurance coverage.

P.L. 105-200 required the Secretary of the Department of Health and Human Services (HHS) to submit a report to Congress containing recommendations on a medical support indicator and its integration with the new performance-based incentive funding system established for the federal Child Support Enforcement program. The Medical Support Incentive Work Group (MSIWG), which was formed

pursuant to this mandate, recommended in 2000 that a medical support performance measure be delayed because of the lack of reliable historical information on medical support. Three of the data elements suggested by the group are now part of the data-reporting form OCSE-157 that states are required to complete. The three elements are: (1) cases where medical support is ordered (includes cash medical support and/or health insurance coverage); (2) cases where health insurance specifically is ordered; and (3) cases where health insurance is provided as ordered. These data elements appear in **Table 2**.

Table 2 shows that in FY2001, only 5.452 million (49%) of the 11.050 million families with child support orders had an order that included health insurance. The inclusion of health insurance in child support orders varied considerably from state to state, from a high of 100% in South Carolina and 83% in Idaho to a low of 2.1% in the District of Columbia and 10% in Kansas.

Moreover, only 18% of health insurance orders actually resulted in health benefits. In other words, in 2001, only 18% of custodial families expecting to receive health benefits for their children actually did so. Again, there was wide variation by state; in Ohio health insurance was provided as ordered in 86% of the cases that included a health insurance order; the comparable figure in Vermont was 76%. At the other end of the spectrum, nine states reported that less than 2% of the cases that included a health insurance order actually provided health insurance coverage.

Table 2. Medical Child Support, FY2001

States	CSE cases with child support orders	CSE cases with medical support order	Health insurance included	Health insurance provided	Health insurance included as % of CSE orders	Health insurance provided as % of health insurance orders
Alabama	172,951	87,714	86,675	599	50.1%	0.7%
Alaska	36,532	29,623	29,591	9,378	81.0	31.7
Arizona	140,993	51,284	50,974	808	36.2	1.6
Arkansas	103,633	70,447	56,424	9,558	54.4	16.9
California	1,409,690	1,019,147	964,951	218,067	68.5	22.6
Colorado	112,463	71,958	71,951	5,960	64.0	8.3
Connecticut	125,622	74,928	74,884	12,508	59.6	16.7
Dist. of Columbia	31,795	22,637	660	-	2.1	0.0
Florida	391,027	94,854	78,550	2,813	20.1	3.6
Georgia	313,807	1,710	107,208	20,043	34.2	18.7
Guam	5,909	3,928	3,910	438	66.2	11.2

States	CSE cases with child support orders	CSE cases with medical support order	Health insurance included	Health insurance provided	Health insurance included as % of CSE orders	Health insurance provided as % of health insurance orders
Hawaii	55,424	17,853	17,801	2,385	32.1	13.4
Idaho	57,991	48,215	48,158	5,274	83.0	11.0
Illinois	36,386	96,577	95,752	25,927	28.5	27.1
Indiana	244,552	217	57,669	644	23.6	1.1
Iowa	145,054	92,601	91,964	21,098	63.4	22.9
Kansas	85,602	9,568	8,629	791	10.1	9.2
Kentucky	204,658	74,662	68,710	3,430	33.6	5.0
Louisiana	166,596	126,718	126,685	702	76.0	0.6
Maine	55,868	36,359	23,143	1,034	41.4	4.5
Maryland	211,504	96,604	96,029	37,653	45.4	39.2
Massachusetts	166,329	40,572	40,568	917	24.4	2.3
Michigan	762,254	424,451	380,402	60,352	49.9	15.9
Minnesota	180,678	131,199	101,441	36,277	56.1	35.8
Mississippi	139,287	62,077	37,404	6,794	26.9	18.2
Missouri	294,127	207,674	204,314	24,619	69.5	12.0
Montana	30,217	24,184	24,001	6,489	79.4	27.0
Nebraska	72,875	22,180	22,132	-	30.4	0.0
Nevada	56,635	41,117	40,284	2,142	71.1	5.3
New Hampshire	30,497	21,065	18,209	1,698	59.7	9.3
New Jersey	267,107	147,156	147,036	41,203	55.0	28.0
New Mexico	29,837	17,255	17,226	-	57.7	0.0
New York	661,395	280,175	267,221	-	40.4	0.0
North Carolina	303,751	183,036	179,548	56,508	59.1	31.5
North Dakota	24,140	22,802	19,025	7,759	78.8	40.8
Ohio	625,300	279,339	103,454	88,535	16.5	85.6
Oklahoma	94,469	75,426	72,613	-	76.9	0.0

States	CSE cases with child support orders	CSE cases with medical support order	Health insurance included	Health insurance provided	Health insurance included as % of CSE orders	Health insurance provided as % of health insurance orders
Oregon	161,157	118,119	118,119	26,245	73.3	22.2
Pennsylvania	489,726	171,116	122,438	37,858	25.0	30.9
Puerto Rico	146,368	51	43	16	0.0	37.2
Rhode Island	32,829	20,082	20,081	3,918	61.2	19.5
South Carolina	149,464	150,088	150,081	12,531	100.4	8.3
South Dakota	25,888	19,042	19,042	4,123	73.6	21.7
Tennessee	195,714	105,104	88,455	12,457	45.2	14.1
Texas	633,327	483,489	468,772	31,752	74.0	6.8
Utah	63,862	57,437	4,909	21,559	70.3	48.0
Vermont	21,557	9,225	9,218	7,011	42.8	76.1
Virgin Islands	-	-	-	-	-	-
Virginia	283,587	150,318	150,218	13,100	53.0	8.7
Washington	278,674	18,355	217,606	56,012	78.1	25.7
West Virginia	85,450	44,517	29,314	2,106	34.3	7.2
Wisconsin	266,665	146,967	145,127	31,104	54.4	21.4
Wyoming	31,246	16,706	10,349	1,427	33.1	13.8
Total	11,049,610	5,840,197	5,452,220	976,387	49.3%	17.9%

Source: Table prepared by the Congressional Research Service based on data from the Office of Child Support Enforcement.

SIPP Data

A report prepared in 2000 by the Urban Institute provides longitudinal data on the health care coverage of children living with their mothers (and apart from their fathers). The report is based on analysis of the 1993 Survey of Income and Program Participation (SIPP), a longitudinal survey containing detailed income and demographic information on a nationally representative sample of approximately 20,000 households. Two tables from the report are presented in **Appendix B**.

Table B.1 shows that 37% of the child support awards ordered in 1993 included an award of health insurance coverage by the noncustodial father, 16% required the custodial parent to provide coverage, 9% made some other provision for medical

costs such as requiring the noncustodial parent to pay medical costs directly or including cash medical support in the child support award. Thirty-eight percent (38%) of child support awards ordered in 1993 included no provision for health care coverage of any kind.

Table B.2 examines the health care coverage of custodial children based on whether the noncustodial father was required to provide health care coverage for his dependent children. The second panel of Table B.2 provides information on the health care coverage status of custodial families in which the father was ordered to provide health care coverage for his dependent children. It shows that 68% of the custodial families reported receiving health care coverage from the noncustodial father in at least one month of 1993, 17% reported the use of the custodial parent's health insurance to provide health care for the children, 11% relied exclusively on Medicaid or Medicare, and 4% were uninsured. Sixty-five percent of the custodial families reported that the private coverage from the noncustodial father or custodial mother was valid for all 12 months of the year.

The author of the report made the following remarks regarding the current applicability of the 1993 findings.

> The results presented in this paper are based on data from 1993, the most recent year for which information on nonresident fathers is readily available. To what extent have changes since 1993 affected nonresident fathers' ability to provide health care coverage? If nonresident fathers have experienced the same health care coverage trends as the overall workforce, then the flattening out of several health care coverage trends since 1993 suggests that the findings are still relevant.[11]

Although SIPP also collected information on health insurance coverage of custodial children in its 2001 topical module questionnaire, those data are not yet available.

Data Summary

The national Census Bureau data, which reflect the universe of custodial families, show that in 1999 about 56% of mothers awarded child support payments had health insurance included in their child support award. It also showed that only 49% (i.e., 49% of the 56%) of custodial mothers expecting to receive health benefits for their children actually did so. In contrast, the CSE program data, which reflect welfare families who are automatically eligible for CSE services and nonwelfare families who have applied for CSE services, show that in FY2001 about 49% of child support awards included a health insurance order. Further, only 18% of health

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[11] Laura Wheaton, The Urban Institute, Prepared for Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, Contract No. HHS-100-95-0021, *Nonresident Fathers: To What Extent Do They Have Access to Employment-Based Health Care Coverage?*, June 2000, p. 18 of web version [http://fatherhood.hhs.gov/ncp-health00/report.htm]. (Hereafter cited as *Nonresident Fathers*.)

insurance orders were provided as ordered (i.e., only 18% of custodial mothers expecting to receive health benefits for their children actually did so).

The CSE program data show a less effective medical support effort than the national Census Bureau data. This may be because noncustodial parents that are not part of the CSE program have more income and are more able to provide medical support for their children. Even so, as noted earlier, the national data also indicate that much more needs to be accomplished with regard to establishment and enforcement of medical support.

Establishment of Health Insurance Order as Part of Child Support Award/Order. As noted, the CSE program data indicate that in 2001, only 49% of families with child support awards had a health insurance order included as part of their child support award/order. An HHS IG report released in June 2000 found "*child support agencies deficient in pursuing health insurance availability...*" The report noted that CSE staff indicated that while they do try to obtain employment and health insurance information pertaining to noncustodial parents, they believe their primary efforts should be spent in obtaining cash child support payments.[12] Some observers contend that medical support provisions should be expanded to require both noncustodial and custodial parents to disclose information about actual and potential private health care coverage to help CSE agencies better and/or more quickly determine whether private health insurance coverage is available to the dependent children. Also, during the last several years there has been a decline in the number of employers that provides health insurance for their employees (which is the foundation of the current medical child support system), and among employers who do provide health insurance, the share of health insurance costs borne by employees has increased.

Enforcement of Health Insurance Order. Of perhaps more significance is the fact that only 18% of CSE families with a health insurance order included in their child support award actually received the health care coverage mandated by the order (2001 data). Clearly, enforcement of the health insurance order can only come after the health insurance order has been established. However, higher enforcement levels are not necessarily correlated to higher levels of establishment of health insurance coverage.

Some reasons for the low compliance with health insurance orders may be that the health care coverage is not (1) affordable — health care costs have risen dramatically over the last decade and those costs have in many instances been passed on to the beneficiary, so that noncustodial parents who can no longer meet the premium fees, co-payments, deductibles, and other costs associated with the coverage and may let the coverage lapse or terminate the coverage altogether; (2) accessible — the rise in the use of Health Maintenance Organizations to deliver health insurance coverage has led to many cases in which the dependent child is not in the HMO service area and therefore not eligible for coverage; (3) stability — not all workers are full-time, year-round employees, thus in the cases of temporary or

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[12] U.S. Department of Health and Human Services, Office of Inspector General, *Medical Insurance for Dependents Receiving Child Support*, OEI-07-97-00500, June 2000, p. 2.

seasonal workers, any access they had to health care coverage would generally end when their employment ended.

Issues

To improve establishment and enforcement of medical child support, there are a range of health coverage options. Generally speaking for the last several years the focus has been on obtaining private health care coverage exclusively from noncustodial parents. The extent to which custodial parents work and have access to employer-sponsored health insurance has increased significantly during the last 20 years. Similarly, Medicaid coverage based on child poverty has also increased. Today, in many cases health care coverage is more accessible if it is based on the custodial parent's coverage.[13] Moreover, over the last several years health care costs have dramatically increased, and it can no longer be assumed that all employer-sponsored health insurance is affordable. Requiring and enforcing expensive health care insurance may negatively affect the custodial parent and child as well as the noncustodial parent. Most policymakers agree that health care coverage must be available, accessible, affordable, and stable. Observers state that if the goal is to reduce the number of uninsured children with child support orders, in some cases, the only way to obtain this result will be to rely on publicly-funded health care.

As indicated by the data discussed earlier, federal law has not been fully effective in addressing medical child support. However, two provisions of federal law have yet to be fully implemented. P.L. 105-200 stipulated that a medical child support incentive payment system be developed — that has not yet happened. Further, although the National Medical Support Notice was promulgated December 27, 2000 and became effective on March 27, 2001, as discussed below, only half of the states are using it.

The discussion below provides context and background to some of the issues that are preventing states from effectively establishing and enforcing medical child support.

Slow Progress in Establishing and Enforcing Medical Support

As mentioned elsewhere in this report, the 1984 law (P.L. 98-378) basically requires CSE agencies to secure medical support information, and to secure and enforce medical support obligations whenever health care coverage is available to the noncustodial parent at a reasonable cost. Recognizing that states were making slow progress in establishing and enforcing medical support, Congress in the 1993 amendments (P.L. 103-66) sought to remove some of the barriers to effective medical support enforcement. The 1993 law prohibited discriminatory health care coverage practices, created "qualified medical child support orders" to obtain coverage from

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[13] U.S. Department of Health and Human Services, Administration for Children and Families, Office of Child Support Enforcement, *21 Million Children's Health: Our Shared Responsibility — The Medical Child Support Working Group's Report*, June 2000, p. 2-10. (Hereafter cited as *21 Million Children's Health*.)

group health plans that were covered by the Employee Retirement Income Security Act (ERISA), and allowed employers to deduct the costs of health insurance premiums from the employee/obligor's paycheck. Even with the enactment of the 1996 welfare reform law (P.L. 104-193), which required inclusion of health care coverage in all child support orders established or enforced by CSE agencies, it is generally agreed that the establishment and enforcement of medical support has remained inadequate.

A 1998 law (P.L. 105-200) required the development and use of a "National Medical Support Notice" and also established a Medical Child Support Working Group charged with making recommendations to overcome the barriers to effective enforcement of medical support.[14] The Working Group submitted a report to the Secretaries of the Departments of Health and Human Services (HHS) and Labor in June 2000 containing 76 recommendations related to medical child support. These recommendations have not been considered by Congress.

Although some critics claim that much more needs to be accomplished with regard to the provision of medical support for children receiving CSE services, some analysts contend that the federal government has made tremendous strides. They note the following accomplishments. The federal government has moved from recoupment of Medicaid costs to pursuit of private medical support. The federal government has moved from simply petitioning for medical support to requiring that medical support be included in all CSE orders. The federal government has moved from simply establishing medical support to requiring a uniform national medical support notice that must be honored by employer group health plans. They conclude that the 19-year period from 1984-2003 encompasses much progress in both establishing medical support orders and in enforcing those orders.

Some proponents advocate the collection of medical support through income withholding. They assert that child support and medical support should be fully integrated and enforced primarily through income withholding. They point out that income withholding as a percentage of all child support collections went from about 50% right before automatic income withholding was mandated in 1994 to 65% of collections in FY2002. They contend that just as income withholding has been so successful for cash child support, so too could medical support benefit from the mandatory use of income withholding.[15] Others warn that income withholding is too intrusive and does not account for changing financial circumstances. They also

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[14] The Medical Child Support Working Group, congressionally-mandated by P.L. 105-200, included 30 members representing HHS and the Department of Labor (DOL), state CSE directors, state Medicaid directors, employers (including small business owners and payroll professionals), sponsors and administrators of group health plans, organizations representing children potentially eligible for medical support, state medical child support programs, and organizations representing state CSE programs.

[15] Paula Roberts, Center for Law and Social Policy, *Improving Health Care Coverage in the Child Support System*, Apr. 1997, p. 11-14. See also Anne R. Gordon, Urban Institute Press, Child Support and Child Well-Being, *Chapter 3, Implementation of the Income Withholding and Medical Support Provisions of the 1984 Child Support Enforcement Amendments*, p. 61-92.

contend that the combination of both child support and medical support may exceed the limits imposed by the Consumer Credit Protection Act.[16]

Examining the Health Care Coverage of Both Parents

According to federal regulations [45 CFR 303.31(b)(1)], if the custodial parent is already providing satisfactory private health care coverage for herself and the children, state CSE agencies are not required to petition the court or administrative agency to include private health insurance coverage that is available to the noncustodial parent at reasonable cost in new or modified child support orders. This means that if the custodial parent is bearing the full cost of premiums, co-payments and deductibles — without assistance from the noncustodial parent — the CSE agency will take no action. In such cases, cash child support may be used to pay health care costs. In some cases, a child may have private health care coverage but live in poor housing or lack adequate food or clothing.[17] Some observers argue that health insurance should be an adjunct to, not a substitute for, the noncustodial parent's obligation to provide financial support for his or her child; they note that when insurance costs are subtracted from the noncustodial parent's financial obligation, the custodial parent has less resources to spend in the best interest of the child.[18] Others argue that when medical child support is not provided, the custodial parents may not be able to oversee the medical health of their children.

According to the Medical Child Support Working Group, it often is assumed that only the noncustodial parent has access to private health insurance. It cites a number of statistics that affirms this is a fallacy. It recommends that a new paradigm should be adopted in which coverage available to both parents is examined in determining the medical support obligation. Under this paradigm, if only the custodial parent has coverage, that coverage should be ordered and the noncustodial parent should contribute toward the cost of such coverage. When both parents are potentially able to provide coverage, the coverage available through the custodial parent (with a contribution toward the cost by the noncustodial parent) should normally be preferred because it — (1) most likely is accessible to the child, (2) involves less difficulty in claims processing for the custodial parent, the provider, and the insurer, and (3) minimizes the enforcement difficulties of the CSE agency or private attorney responsible for the case.[19]

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[16] The Federal Consumer Credit Protection Act (Title 15 USC Sec. 1673) limits garnishment to 50% of disposable earnings for a noncustodial parent who is the head of a household, and 60% for a noncustodial parent who is not supporting a second family. These percentages increase by 5 percentage points, to 55% and 65% respectively, when the arrearages represent support that was due more than 12 weeks before the current pay period.

[17] Paula Roberts, Center for Law and Social Policy, *Failure to Thrive: The Continuing Poor Health of Medical Child Support*, June 2003, p. 5-6. (Hereafter cited as *Failure to Thrive*.)

[18] Daniel R. Meyer, University of Wisconsin, Madison, Institute for Research on Poverty, *Health Insurance and Child Support*, Discussion Paper, DP#1042-94, Sept. 1994, p. 5.

[19] *21 Million Children's Health*, p. 2-19.

Some analysts caution that this policy may cause conflict if the state has to enforce a medical support order against the custodial parent, especially if the custodial parent contends that the reason the medical obligation was unmet was because the noncustodial parent failed to make his or her contribution. Such conflict may occur because there is much confusion over whom the CSE attorney represents. Most custodial parents believe that the CSE agency represents them when in fact the CSE agency represents the state.

Accessibility of Health Care Coverage

In general, private health care coverage that is available to the *custodial* parent usually is accessible to the child even if the plan coverage has a limited service area, as is the case with many Health Maintenance Organizations (HMOs). However, this may *not* be the case when it is the *noncustodial* parent whose health insurance coverage is being used, particularly if that coverage is provided through an HMO.[20] Thus, for children living far from their noncustodial parent, managed care reduces the attractiveness of coverage under the noncustodial parent's plan relative to other options for health care coverage. For example, HMO coverage in California may be useless to a child living in Massachusetts. Likewise, coverage available in upstate New York may be too far away to be useful to a child living in New York City. According to one report, since managed care is now the norm and only 40% of noncustodial fathers live in the same city or county as their children, this can be a serious problem.[21]

Under the Medical Child Support Working Group's paradigm, when private health care coverage is available to a child, the CSE agency should consider the accessibility of covered services before it decides to pursue the coverage. According to the Working Group, children should not be enrolled in any plan whose services/providers are not accessible to them, unless the plan can provide financial reimbursement for services rendered by alternate providers.[22]

The Working Group recommended that federal regulations be developed to define "accessible" coverage and that it be made clear that coverage that is not accessible should not be ordered. The Working Group reported the following with regard to a definition of "accessible":

> Coverage is accessible if the covered children can obtain services from a plan provider with reasonable effort by the custodial parent. When the only health care option available to the noncustodial parent is a plan that limits service coverage to providers within a defined geographic area, the decision maker should determine whether the child lives within the plan's service area. If the

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[20] Noncustodial parents enrolled in other managed care arrangements, such as a Preferred Provider Organization (PPO) or Point of Service (POS), should be able to extend coverage to children living elsewhere, since these plans allow the use of out-of-network medical providers. But, reliance on out-of-network medical providers usually results in higher out-of-pocket costs and/or restricted benefits.

[21] *Failure to Thrive*, p. 8.

[22] *21 Million Children's Health*, p. 2-19.

> child does not live within the plan's service area, the decision maker should determine whether the plan has a reciprocal agreement that permits the child to receive coverage at no greater cost than if the child resided in the plan's service area. The decision maker should also determine if primary care is available within the lesser of 30 minutes or 30 miles of the child's residence. If primary care is not available within these constraints, the coverage should be deemed inaccessible.[23]

In addition, the Medical Child Support Working Group cautioned that to be deemed accessible, the health care coverage also should be stable. The Working Group maintained that the decision maker should base accessibility partly on whether it can reasonably be expected that the health care coverage will remain effective for at least one year, based on the employment history of the parent who is to provide the coverage. In other words, it is the Working Group's opinion that it might not always be feasible to pursue health insurance coverage in the case of parents who are seasonal workers. Some observers contend that if noncustodial parents cannot provide continuous health care coverage for their dependent children, it may be in the best interest of the child to receive private health care coverage from the custodial parent or coverage from Medicaid or the State Children's Health Insurance Program (SCHIP) Under SCHIP, which was established in 1997, low-income children may be better off without any coverage from the noncustodial parent, if that parent is unable to provide continuous coverage because some states do not grant SCHIP eligibility until children have been uninsured for a waiting period of three or more months.[24]

Incentives for Seeking Medical Support

As noted earlier, the federal government provides 66% of the funding for most CSE program activities, including those related to medical support. In order to receive any federal funding, states and/or local governments must provide 34% of the funds needed to operate their CSE programs. In the past, when Congress wanted to encourage activity in an area it considered vital to the effectiveness of the CSE program, it offered federal financial participation (FFP) at a higher than normal level. For example, Congress provided enhanced FFP to encourage paternity establishment and automation in the CSE program.[25]

The Medical Child Support Working Group contends that Congress should provide enhanced FFP at a 90% rate for medical child support activities to encourage states to more aggressively pursue medical support enforcement. The Working

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[23] Ibid., p. 3-10.

[24] *Nonresident Fathers*, p. 11-12.

[25] The federal government provides 90% matching funds for laboratory costs incurred in determining paternity. In addition, for many years the federal government also reimbursed state costs of designing and implementing automated data processing and information retrieval systems at a 90% match rate. During the period FY1996-FY2001, the federal matching rate was reduced to 80% of a capped amount. Beginning October 1, 2001 (i.e., FY2002), the federal matching rate for CSE computerization was reduced back to 66%.

Group's recommendation limits the 90% matching requirement for medical support to 5 years.

P.L. 105-200 (enacted in 1998) also required the HHS Secretary, in consultation with state CSE directors and representatives of children potentially eligible for medical support, to develop a new medical support incentive measure based on the state's effectiveness in establishing and enforcing medical child support obligations. The medical support incentive was to be part of the new revenue-neutral performance-based child support incentive system, established for the overall program in 1998. The 1998 law required that a report on this new incentive measure be submitted to Congress not later than October 1, 1999. According to the House report on the legislation:

> Several witnesses who appeared before the Committee recommended that we consider including medical child support as a performance measure. After discussion, the Committee decided not to include this measure because of the lack of information about the reliability of state data on medical support as well as lack of historical information about state performance on the measure that could be used to estimate payments. However, because medical support is of central importance to a good child support system, the Committee decided to ask the Secretary to study the feasibility of using medical support as a performance measure and to report her findings to Congress.[26]

Pursuant to this mandate, the HHS Secretary formed the Medical Support Incentive Work Group (MSIWG).[27] The work group met twice over a period of nine months to make recommendations to the Secretary. The work group recommended that the development of the medical support incentive be delayed until 2001 so that it could obtain the necessary data and develop an appropriate measure. This recommendation was included in the Secretary's report to Congress.

A reconstituted MSIWG was later convened and — in September 2001 — recommended that the HHS Secretary not develop a medical support performance measure for incorporation into the existing CSE incentive payment system. Again noting the lack of data, the second MSIWG recommended that a measure be developed, but not for incentive payment purposes. To date, the HHS Secretary has not acted on this report. Hence, a recommendation to Congress has not been made and there remains no incentive payment for medical support activities.

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[26] U.S. Congress, House Committee on Ways and Means, *Child Support Performance and Incentive Act of 1998*, report to accompany H.R. 3130, 105th Cong., 2nd sess., H.Rept. 105-422 (Washington: GPO, 1998), p. 35.

[27] In the report to Congress, the group was called the Medical Support Indicator Work Group. The Group met on June 2, 1998 and again on March 2-3,1999. The HHS Secretary submitted the required report to Congress on June 23, 1999.

What Is Meant by "Reasonable Cost"?

CSE agencies are required to pursue private family health coverage whenever it is available at reasonable cost. Federal regulations state that "health insurance is considered reasonable in cost if it is employment-related or other group health insurance." The definition deeming employment-related coverage or group (e.g., union) health insurance policies to be per se reasonable in cost was first promulgated in 1985. It was justified by a 1983 study by the National Center for Health Services Research, which found that employers paid 72% of the premium cost for low-wage employees. The federal Office of Child Support Enforcement (OCSE) thus concluded that most employment-related or other group health insurance is inexpensive to the employee/noncustodial parent. Rising health care costs have changed the picture. Recent research indicates that the required employee contribution for health care coverage represents a much larger share of family income for low-income workers. Some data suggest that on average, employee contributions to family health care coverage premiums are equal to 45% to 52% of the typical cash child support payment.[28]

Although federal regulations (45 CFR section 302.56) require that child support guidelines "provide for the child(ren)'s health care needs, through health insurance coverage or some other means," they do not stipulate how this is to be done. In practice, integrating child support and medical support can be difficult. Most states operate under the position that if the custodial parent provides the health care coverage, the cash support award is suppose to increase, to reflect some contribution from the noncustodial parent toward the cost. If the noncustodial parent provides the coverage, the cash support award is suppose to decrease, to reflect the fact that the noncustodial parent is subsidizing the cost of health care coverage through a separate deduction from wages toward the premium. The results may be problematic in that if the premium associated with the health care coverage is too high, cash support will be substantially reduced, leaving the custodial parent without enough money to take care of the child's food, clothing, and shelter needs. If cash support is not adjusted downward, however, poorer noncustodial parents will pay an unreasonably high portion of their income as support.[29]

Under the Medical Child Support Working Group's paradigm, in deciding whether to pursue private coverage, the cost of coverage should be considered. To the maximum extent possible, public dollars (through, for example, enrollment in Medicaid or the State Children's Health Insurance Program (SCHIP) should be the payment of last resort. Moreover, according to the Working Group, private insurance should not be ordered when its cost significantly lowers the amount of cash child support available to meet the child's basic needs and the child is eligible for some other form of coverage.[30]

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[28] Ibid., p. 3-10 — 3-15.

[29] Ibid., p. 3-11 — 3-15.

[30] Ibid., p. 2-19.

According to a Policy Interpretation Questions memorandum,[31] issued by the Office of Child Support Enforcement, concerning "reasonable cost" of medical support, states in which the child support order is established by the courts can enact statutes governing their courts that define "reasonable cost" in a way that the state deems appropriate and still meet federal requirements. For example, under the Texas statute (Section 154.181(e) of the Texas Family Code) "reasonable cost" means the cost of a health insurance premium that does not exceed 10% of the responsible parent's monthly net income.

In contrast, states that set the child support order administratively through their CSE agencies would be subject to federal law and regulations, which stipulate that health insurance is considered reasonable in cost if it is employment-related or other group health insurance.

The Working Group recommended that federal policy be changed to reflect the view that if the cost of providing private health insurance coverage does not exceed 5% of the gross income of the parent who provides coverage, then the cost should be deemed reasonable, regardless of whether the child support order was established by the courts or administratively by the state CSE agency.[32]

Cooperation Among Child Support, Medicaid, and SCHIP Agencies

Even though private health care coverage has advantages over public coverage — namely greater likelihood of full family coverage, a wider range of providers, no stigma, less taxpayer burden, and greater satisfaction with various aspects of care[33] — for the 8.5 million children who did not have any health insurance coverage in 2002, public health care coverage may need to be pursued if private health care coverage is not available or not accessible. There is general agreement that the CSE agency should work more closely with Medicaid/SCHIP to ensure that children who have access to private health care coverage obtain such coverage, and that those who are eligible for publicly-subsidized health coverage are covered by Medicaid or SCHIP.

Alternate Methods to Offset Health Insurance or Medicaid Costs. Although focused solely on the state of Connecticut, a 1998 report by the HHS Office of Inspector General (OIG) found many noncustodial parents who were required by court order to provide health care coverage to their children were unable to meet their obligation because either their employers did not offer health insurance or available health insurance was not reasonable in cost. One of the report's recommendations

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[31] U.S. Department of Health and Human Services, Administration for Children and Families, Office of Child Support Enforcement, Policy Interpretation Questions, PIQ-03-08, *Medical Support in Child Support Orders-Definition of Reasonable Cost*, July 25, 2003.

[32] *21 Million Children's Health*, p. 3-11 — 3-15.

[33] Amy J. Davidoff, Bowen Garrett, Diane M. Makuc, and Matthew Schirmer, The Urban Institute, *Children Eligible for Medicaid but Not Enrolled: How Great a Policy Concern?*, series A, no. A-41, Sept. 2000, p. 6.

was for Connecticut to require noncustodial parents to pay all or part of the Medicaid premiums for their dependent children. The report estimated that Connecticut would save about $11.4 million annually in combined federal and state Medicaid costs if it required noncustodial parents to offset Medicaid premiums paid by the state on behalf of the children of these noncustodial parents.[34]

Similarly, a 2003 HHS OIG report focused on North Carolina found that about $17.4 million could have been collected from the noncustodial parents of 30,987 children to partially offset the Medicaid cost incurred by the state and federal governments to provide health care to these children.[35] Although federal law does not require noncustodial parents to provide medical support if the employer does not offer health insurance or the insurance is too costly, states have the authority to modify state laws to require noncustodial parents to contribute to their dependent children's Medicaid costs.

In cases where a parent has access to private health care coverage but it is too costly, the child may then be enrolled in Medicaid, if eligible. In such cases, it may be less expensive for the state if the child were enrolled in the private health care coverage. For example, the noncustodial parent's share of the private health insurance premium might be less than what the state pays an HMO for the child's Medicaid coverage. In that case, many experts believe that it would make sense for Medicaid to pay the private health coverage premium.[36] Federal law allows individuals to obtain private health care coverage with a public subsidy. Specifically, section 1906 of the Social Security Act allows state Medicaid agencies to use Medicaid funds to purchase group health insurance coverage if such coverage is available to a Medicaid-eligible individual.

Closing the Gap Between Those Eligible for Medicaid and Those Enrolled. In many cases, children are uninsured because private health insurance coverage is not available through either parent, and the custodial parent has not enrolled the child in the available public health care system, i.e., Medicaid or SCHIP. One study estimates that enrolling uninsured, child support-eligible children in Medicaid or SCHIP could reduce the share of these children who are uninsured from 15% to 3%. According to some analysts, requiring that the child be enrolled in Medicaid or SCHIP (if eligible) when private coverage is not available should be a standard part of the child support process. Also, as mentioned above, consideration could also be given to having the noncustodial parent contribute to any premiums, co-payments, or deductibles associated with SCHIP coverage if the state in which the child is to be enrolled has a separate SCHIP program that imposes these costs. These

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[34] U.S. Department of Health and Human Services, Office of Inspector General, *Review of Availability of Health Insurance for Title IV-D Children*, A-O 1-97-02506, June 1998.

[35] U.S. Department of Health and Human Services, Office of Inspector General, *Review To Increase the Number of Noncustodial Parents Providing Medical Support to Their Children and Reduce Medicaid Costs in North Carolina*, A-04-02-00013, June 2003.

[36] *Failure to Thrive*, p. 20.

types of procedures might spread the cost more equitably between the parents, and between parents and the state.[37]

If the state does not want to require enrollment in publicly-funded medical programs, it could provide information on the availability of the programs. It has been estimated that 66% of uninsured child support-eligible children are eligible for Medicaid, and another 15% are eligible for SCHIP. One of the main reasons for this lack of health care coverage of children who are eligible for public health care programs is that many parents do not know about Medicaid and SCHIP or do not know how to enroll their children. About one-third of the parents of eligible but not-enrolled children reported that they had not heard of Medicaid or SCHIP. Another 10% had difficulty with the enrollment process. An option would be for the CSE agency to provide parents with information about these programs and assist them in the enrollment process.[38]

The ability to move back and forth between the noncustodial parent's health insurance plan and an alternative source of coverage is an important factor in determining the best source of coverage for a child whose noncustodial parent has access to employment-based health care coverage on an irregular or seasonal basis. According to one author:

> Transitions to and from Medicaid can be quite seamless, since children can remain enrolled in Medicaid even when they are also covered by the nonresident parent's health care plan (in which case, the nonresident parent's health care plan takes precedence). However, if the alternative source of coverage is SCHIP, then the transition may not be seamless, since some states require a child to be uninsured for three or more months before gaining eligibility. Unless some exemption can be made for children losing coverage from a nonresident parent, SCHIP-eligible children whose nonresident parent can provide only irregular access to employment-based health care coverage may be better off if some other form of medical support is required, such as a contribution to the health plan premiums paid by the custodial family, or contributions toward co-payments and deductibles.[39]

Legislative Timetables for Medical Support Have Not Been Met

P.L.105-200 provided for a uniform manner for states to inform employers about their need to enroll the children of noncustodial parents in employer-sponsored health plans. It required the CSE agency to use a standardized "National Medical Support Notice" (developed by HHS and the Department of Labor) to communicate to employers the issuance of a medical support order. Employers are required to accept the form as a "Qualified Medical Child Support Order" (QMCSO) under

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[37] Ibid., p. 17.

[38] Ibid., p. 17-20.

[39] *Nonresident Fathers*, p. 16-17.

ERISA.[40] An appropriately completed national medical support notice is considered to be a QMCSO and as such must be honored by the employer's group health plan.

P.L. 105-200 also requires plans sponsored by churches and state and local governments to provide benefits in accordance with the requirements of an appropriately completed NMSN. The legislation envisioned that all states would be using the NMSN by October 1, 2001 or, at the latest, by the end of first legislative session to occur after that date, if state legislation was needed. It also required employers to honor any appropriately completed NMSN and send it to the appropriate plan administrator within 20 business days. The plan administrator has 40 days from the date on the NMSN to respond to the CSE agency. Finally, employers were required to notify the state CSE agency if the employee was terminated thereby alerting the CSE agency of the need to enforce medical support against any new employer by issuing another NMSN.

A draft NMSN was issued for public comment on November 15, 1999. Changes were made in response to comments from the Medical Child Support Working Group, as well as the public. The Department of Labor and the Department of Health and Human Services adopted final regulations on December 27, 2000, implementing the National Medical Support Notice provisions of the Child Support Performance and Incentive Act of 1998 (P.L. 105-200). On January 26, 2001, the Federal Register published a notice that delayed the effective date of the final NMSN regulations until March 27, 2001.

Although Congress required all state CSE agencies to use the NMSN once it was promulgated, few states had implemented it by the target date of October 2001. According to OCSE, 37 states and territories had to delay implementation of the NMSN because their legislatures needed to pass the required legislation. According to National Women's Law Center, as of September 2002, about 30 states had passed

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[40] At the same time that the QMCSO provisions were added to ERISA, Congress also added section 1908 (later changed to section 1908A) to the Social Security Act. Section 1908A of the SSA conditions state eligibility for Medicaid matching funds on the enactment of certain specified state laws relating to medical child support. Under section 1908A states must enact laws under which insurers (including group health plans) may not deny enrollment of a child under the health coverage of the child's parent on the ground that the child is born out of wedlock, not claimed as a dependent on the parent's tax return, or not in residence with the parent or in the insurer's service area. Section 1908 also sets out rules for states to require of employers and insurers when a parent is ordered by a court or administrative agency to provide health coverage for a child and the parent is eligible for health coverage from that insurer or employer, including a provision which permits the custodial parent or the state CSE agency to apply for available coverage for the child, without regard to open season restrictions. **Source:** *Federal Register*, v. 65, no. 249, Dec. 27, 2000, p. 82128.

NMSN implementation legislation.[41] According to the Center on Law and Social Policy, as of April 4, 2003, about half the states were not yet using the NMSN.[42]

Federal law mandates that states have procedures under which all child support orders are required to include a provision for the health care coverage of the child (section 466(a)(19) of the Social Security Act). Federal law does not, however, stipulate state use of the NMSN in the CSE state plan requirements on provision of health care coverage.[43] Thus, a state that does not use the NMSN is not considered to be in noncompliance with the state CSE plan, and thereby is not subject to a financial penalty. Some observers contend that imposing financial sanctions on states that do not use the NMSN could increase its use and thereby increase enforcement of medical child support. Some states contend that the NMSN is much too long and cite the expense of mailing such a lengthy document to a large number of employers. Further, others note that federal law does not require that states impose financial penalties on employers who fail to comply with the NMSN (states, however, can impose such sanctions under state law). According to the National Women's Law Center, some states without relevant employer and plan administrator sanctions are concerned that the lack of sanctions may be an barrier to successful enforcement of medical child support.[44]

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[41] National Women's Law Center, *Implementing the National Medical Support Notice: Insights From State Experiences*, Sept. 2002. (Hereafter cited as *Implementing the National Medical Support Notice*.)

[42] *Failure to Thrive*, p. 14-15.

[43] P.L. 104-193, the 1996 welfare reform law made revisions to section 466(a)(19) of the Social Security Act, including the elimination of the *general* reference to the National Medical Support Notice. Federal law does provide that "in the case in which a noncustodial parent provides such [health care] coverage and changes employment, and the new employer provides health care coverage, the State agency shall transfer notice of the provision to the employer, which notice shall operate to enroll the child in the noncustodial parent's health plan, unless the noncustodial parent contests the notice."

[44] *Implementing the National Medical Support Notice*, p. 2-3.

Appendix A: Legislative History of Medical Child Support Provisions

Just as Temporary Assistance for Needy Families (TANF) recipients must assign their child support rights to the state, so too must Medicaid recipients assign their medical support rights to the state. The impetus for the federal government moving into the arena of financial child support was to reduce federal expenditures on the old Aid to Families with Dependent Children (AFDC) entitlement program (which was replaced in 1996 by the time-limited TANF block grant program). Similarly, the impetus for the federal government moving into the arena of medical support for children (eligible for child support) was to reduce federal costs of the Medicaid program. This section of the report summarizes major medical child support provisions.

P.L. 95-142, Medicare-Medicaid Anti-fraud and Abuse Amendments (H.R. 3), Enacted October 25, 1977

The first link between child support and medical support came as an attempt to recoup the costs of Medicaid provided to public assistance families under Title XIX of the Social Security Act. Just two years after the creation of the CSE (i.e., IV-D of the Social Security Act) program, the Medicare/Medicaid Anti-fraud and Abuse Amendments of 1977 established a medical support enforcement program that *allowed* states to require that Medicaid applicants assign their rights to medical support to the state. Further, in an effort to cover children with private insurance instead of public programs, when available, it permitted CSE and Medicaid agencies to enter into cooperative agreements to pursue medical child support assigned to the state. (It should be noted that activities performed by the CSE agency under a cooperative agreement with the Medicaid agency must be funded by the Medicaid agency.) The 1977 law also required state CSE agencies to notify Medicaid agencies when private family health coverage was either obtained or discontinued for a Medicaid-eligible person.

P.L. 98-369, the Deficit Reduction Act of 1984 (H.R. 4170), Enacted July 18, 1984

P.L. 98-369 *mandated* states to require that Medicaid applicants assign their rights to medical support to the state (Section 1912(a) of the Social Security Act).

P.L. 98-378, the Child Support Enforcement Amendments of 1984 (H.R. 4325), Enacted August 16, 1984

Section 16 of Public Law 98-378, enacted in 1984, required the HHS Secretary to issue regulations to require that state CSE agencies petition for the inclusion of medical support as part of any new or modified child support order whenever health care coverage is available at "reasonable cost" to the noncustodial parent of a child receiving AFDC, Medicaid, or foster care benefits or services. According to federal regulations, any employment-related or other group coverage was considered

reasonable, under the assumption that health insurance is inexpensive to the employee/noncustodial parent.

Implementing Regulations. On October 16, 1985, the Office of Child Support Enforcement (OCSE) published regulations amending previous regulations and implementing section 16 of P. L. 98-378. The regulations required state CSE agencies to obtain basic medical support information and provide this information to the state Medicaid agency. The purpose of medical support enforcement is to expand the number of children for whom private health insurance coverage is obtained by increasing the availability of third party resources to pay for medical care, and thereby reduce Medicaid costs for both the states and the federal government. If the custodial parent does not have satisfactory health insurance coverage, the child support agency must petition the court or administrative authority to include medical support in new or modified support orders and inform the state Medicaid agency of any new or modified support orders that include a medical support obligation. The regulations also required CSE agencies to enforce medical support that has been ordered by a court or administrative process. States receive child support matching funds at the 66% rate for required medical support activities.

Before these 1985 regulations were issued, medical support activities were pursued by CSE agencies only under optional cooperative agreements with Medicaid agencies. Some of the functions that the CSE agency may perform under a cooperative agreement with the Medicaid agency include: receiving referrals from the Medicaid agency, locating noncustodial parents, establishing paternity, determining whether the noncustodial parent has a health insurance policy or plan that covers the child, obtaining sufficient information about the health insurance policy or plan to permit the filing of a claim with the insurer, filing a claim with the insurer or transmitting the necessary information to the Medicaid agency, securing health insurance coverage through court or administrative order, and recovering amounts necessary to reimburse medical assistance payments.

More Regulations. On September 16, 1988, OCSE issued regulations expanding the medical support enforcement provisions. These regulations required the CSE agency to develop criteria to identify existing child support cases that have a high potential for obtaining medical support, and to petition the court or administrative authority to modify support orders to include medical support for these cases even if no other modification is anticipated. The CSE agency also is required to provide the custodial parent with information regarding the health insurance coverage obtained by the noncustodial parent for the child. Moreover, the regulation deleted the condition that CSE agencies may secure health insurance coverage under a cooperative agreement only when it will not reduce the noncustodial parent's ability to pay child support.

P.L. 103-66, the Omnibus Budget Reconciliation Act of 1993 (H.R. 2264), enacted August 10, 1993

Before late 1993, employees covered under their employers' health care plans generally could provide coverage to children only if the children lived with the employee. However, as a result of divorce proceedings, employees often lost custody of their children but were nonetheless required to provide their health care coverage. While the employee would be obliged to follow the court's directive, the employer that sponsored the employee's health care plan was under no similar obligation. Even if the court ordered the employer to continue health care coverage for the nonresident child of their employee, the employer would be under no legal obligation to do so.

Aware of this situation, Congress took the following legislative action in the Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66):

(1) Insurers were prohibited from denying enrollment of a child under the health insurance coverage of the child's parent on the grounds that the child was born out of wedlock, is not claimed as a dependent on the parent's federal income tax return, or does not reside with the parent or in the insurer's service area;

(2) Insurers and employers were required, in any case in which a parent is required by court order to provide health coverage for a child and the child is otherwise eligible for family health coverage through the insurer: (a) to permit the parent, without regard to any enrollment season restrictions, to enroll the child under such family coverage; (b) if the parent fails to provide health insurance coverage for a child, to enroll the child upon application by the child's other parent or the state child support or Medicaid agency; and (c) with respect to employers, not to disenroll the child unless there is satisfactory written evidence that the order is no longer in effect or the child is or will be enrolled in comparable health coverage through another insurer that will take effect not later than the effective date of the disenrollment;

(3) Employers doing business in the state, if they offer health insurance and if a court order is in effect, were required to withhold from the employee's compensation the employee's share of premiums for health insurance and to pay that share to the insurer. The HHS Secretary may provide by regulation for such exceptions to this requirement (and other requirements described above that apply to employers) as the Secretary determines necessary to ensure compliance with an order, or with the limits on withholding that are specified in section 303(b) of the Consumer Credit Protection Act;

(4) Insurers were prohibited from imposing requirements on a state agency acting as an agent or assignee of an individual eligible for medical assistance that are different from requirements applicable to an agent or assignee of any other individual;

(5) Insurers were required, in the case of a child who has coverage through the insurer of a noncustodial parent to: (a) provide the custodial parent with the

information necessary for the child to obtain benefits; (b) permit the custodial parent (or provider, with the custodial parent's approval) to submit claims for covered services without the approval of the noncustodial parent; and (c) make payment on claims directly to the custodial parent, the provider, or the state agency; and

(6) The state Medicaid agency was permitted to garnish the wages, salary, or other employment income of, and to withhold state tax refunds to, any person who: (a) is required by court or administrative order to provide health insurance coverage to an individual eligible for Medicaid; (b) has received payment from a third party for the costs of medical services to that individual; and (c) has not reimbursed either the individual or the provider. The amount subject to garnishment or withholding is the amount required to reimburse the state agency for expenditures for costs of medical services provided under the Medicaid program. Claims for current or past due child support take priority over any claims for the costs of medical services.

P.L. 104-193, the Personal Responsibility and Work Opportunity Reconciliation Act o f 1996 (H.R. 3734), enacted August 22, 1996

Under the 1996 welfare reform legislation, the definition of "medical child support order" in the Employee Retirement Income Security Act (ERISA) was expanded to clarify that any judgment, decree, or order that is issued by a court or by an administrative process has the force and effect of law. In addition, the 1996 welfare reform law stipulated that all orders enforced by the state CSE agency must include a provision for health care coverage. If the noncustodial parent changes jobs and the new employer provides health coverage, the state must send notice of coverage to the new employer; the notice must serve to enroll the child in the health plan of the new employer. (Before enactment of P.L. 104-193, families who were not receiving public assistance benefits could choose not to seek medical support.)

P.L. 105-200, the Child Support Performance and Incentive Act of 1998 (H.R. 3130), enacted July 16, 1998

P.L.105-200 provided for a uniform manner for states to inform employers about their need to enroll the children of noncustodial parents in employer-sponsored health plans. It required the CSE agency to use a standardized "National Medical Support Notice" (developed by HHS and the Department of Labor) to communicate to employers the issuance of a medical support order. Employers are required to accept the form as a "Qualified Medical Support Order" under ERISA. States were required to begin using the national medical support notice in October 2001, although many states had to delay implementation until enactment of required state enabling legislation. An appropriately completed national medical support notice is considered to be a "Qualified Medical Child Support Order" and as such must be honored by the employer's group health plan.

P.L. 105-200 also called for the joint establishment of a Medical Support Working Group by the Secretaries of HHS and Labor to identify impediments to the

effective enforcement of medical support by state CSE agencies and to submit to the Secretaries of HHS and Labor a report containing recommendations addressing the identified impediments.

In addition, the HHS Secretary, in consultation with state CSE directors and representatives of children potentially eligible for medical support, was directed to develop a performance measure based on the effectiveness of states in establishing and enforcing medical support obligations and to make recommendations for the incorporation of the measure in a revenue neutral manner into the Child Support Incentive Payment System, no later than October 1, 1999.

Appendix B: Health Care Coverage of Custodial Children — 1993

Table B.1. Provision for Health Care Costs in the Child Support Award or Agreement, 1993

	Custodial family income level		
	<200% Poverty	**200% Poverty+**	**Total**
Families with a Formal Child Support Award or Agreement	2,858	2,244	5,102
Noncustodial father to provide health care coverage	37%	38%	37%
Custodial family to provide health care coverage	11%	21%	16%
Other provision for health care costs	9%	9%	9%
No provision for health care costs	43%	32%	38%

Source: Laura Wheaton, The Urban Institute, *Nonresident Fathers: To What Extent Do They Have Access to Employment-Based Health Care Coverage?*, June 2000, p. 6 of web version [http://fatherhood.hhs.gov/ncp-health00/report.htm].

Table B.2. Health Care Coverage of Children in Custodial Families in 1993

	Custodial family income level		
	<200% Poverty	**200% Poverty+**	**Total**
All custodial families (thousands)	6,636	3,591	10,227
Health care coverage provided by:*	(100%)	(100%)	(100%)
Noncustodial father	21%	30%	24%
Custodial parent	21%	61%	35%
Medicaid/Medicare only	50%	5%	35%
Uninsured	8%	4%	6%
With private coverage entire year	23%	79%	43%
Custodial families where noncustodial father required to provide health care coverage (thousands)	1,062	846	1,908
Health care coverage provided by:*	(100%)	(100%)	(100%)

	Custodial family income level		
	<200% Poverty	**200% Poverty+**	**Total**
Noncustodial father	66%	71%	68%
Custodial parent	12%	24%	17%
Medicaid/Medicare only	18%	2%	11%
Uninsured	4%	3%	4%
With private coverage entire year	48%	87%	65%
Custodial families with award or agreement, but father not required to provide health care coverage (thousands)	1,795	1,398	3,193
Health care coverage provided by:*	(100%)	(100%)	(100%)
Noncustodial father	15%	16%	15%
Custodial parent	26%	77%	49%
Medicaid/Medicare only	52%	3%	30%
Uninsured	7%	4%	6%
With private coverage entire year	22%	83%	49%
No award or agreement (thousands)	3,779	1,346	5,125
Health care coverage provided by:*	(100%)	(100%)	(100%)
Noncustodial father	10%	18%	12%
Custodial parent	21%	68%	33%
Medicaid/Medicare only	59%	10%	46%
Uninsured	10%	4%	8%
With private coverage entire year	16%	69%	30%

Source: Laura Wheaton, The Urban Institute, *Nonresident Fathers: To What Extent Do They Have Access to Employment-Based Health Care Coverage?*, June 2000, p. 7 and 8 of web version [http://fatherhood.hhs.gov/ncp-health00/report.htm].

* If at least one custodial child receives health care coverage from a given source in at lest one month of the year, then the family is considered to have received health care coverage from that source. The family is placed into the first of the categories that applies to it.